

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF WISCONSIN

SHEILA A. GARD,

Plaintiff,

COMMON GROUND HEALTHCARE COOPERATIVE,
MOLINA HEALTHCARE OF WI, INC.,
FOUNDERS INSURANCE COMPANY,

Involuntary Plaintiffs,

-vs-

Case No. 2:20-CV-256

UNITED STATES OF AMERICA,
UNITED STATES POSTAL SERVICE,
MARK CZECHOLINSKI,

Defendants.

Video Examination of SHEKHAR DAGAM, M.D.,
taken at the instance of the Plaintiff, under and
pursuant to the Federal Rules of Civil Procedure,
before Sarah M. Gilkay, a Certified Realtime
Reporter, Registered Merit Reporter, and Notary
Public in and for the State of Wisconsin, at 4600 W.
Loomis Road, Suite 101, Greenfield, Wisconsin, on
February 23rd, 2022, commencing at 3:34 p.m. and
concluding at 5:15 p.m.



1 APP E A R A N C E S
 2
 3 GRUBER LAW OFFICES, LLC, by
 4 Mr. Eric M. Knobloch
 5 100 East Wisconsin Avenue - Suite 2800
 6 Milwaukee, Wisconsin 53202
 7 Appeared on behalf of the Plaintiff.
 8
 9 UNITED STATES ATTORNEY - EASTERN DISTRICT, by
 10 Mr. Brian E. Pawlak
 11 517 East Wisconsin Avenue
 12 Milwaukee, Wisconsin 53202
 13 Appeared on behalf of the Defendants.
 14
 15 * * * * *

16 ALSO PRESENT
 17 Mr. Keke M. Lewandowski, paralegal
 18 Mr. Jay Church, videographer

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<p>1 neurosurgeon, and my occupation is surgery of 2 different aspects of the central nervous system.</p> <p>3 Q How long have you been a neurosurgeon?</p> <p>4 A I've been in practice for over 20 years.</p> <p>5 Q What I have marked in front of you, Exhibit</p> <p>6 No. 7, appears to be your CV. 7 Would you agree with that?</p> <p>8 A Yes.</p> <p>9 Q Did you have a chance to look over that in the</p> <p>10 few minutes before today's deposition?</p> <p>11 A I did.</p> <p>12 Q And it appears to me that the board</p> <p>13 certification area, this version that we're</p> <p>14 looking at ends in 2018. 15 Have you maintained your board</p> <p>16 certification from 2018 to the present, and are</p> <p>17 you currently board-certified?</p> <p>18 A Yeah. Unfortunately the CV I think is an older 19 version, and so I'm board-certified currently.</p> <p>20 It actually even has the business address as a 21 different address.</p> <p>22 Q Where did you do your undergrad and your medical</p> <p>23 training and residency, please?</p> <p>24 A I did my undergrad at University of 25 California-Berkeley. I did my medical school at</p>	<p>Page 6</p> <p>1 A I currently have privileges at Columbia 2 St. Mary's Ascension in Downtown Milwaukee. I'm 3 also -- I have privileges at the sister 4 hospital, which is in Ozaukee, Columbia 5 St. Mary's Ozaukee. I have privileges at 6 Watertown Memorial Hospital in the city -- in 7 the town of Watertown. And then there is an 8 outpatient surgery center called Milwaukee 9 Surgical Suites where I have privileges as well.</p> <p>10 Q We're here today to talk about treatment that</p> <p>11 was received by Ms. Gard due to that March 24 of</p> <p>12 '17 accident. Throughout the course of this</p> <p>13 time period from that accident forward, have you</p> <p>14 had an opportunity to draft a report, and is</p> <p>15 that your report in front of you as Exhibit 8?</p> <p>16 A Yes, it is.</p> <p>17 Q Based on your report or your other knowledge,</p> <p>18 what is your understanding of the accident that</p> <p>19 Ms. Gard was in?</p> <p>20 A Well, she was in an accident which caused her to 21 have neck pain.</p> <p>22 Q Taking a look at your report there, Doctor, I'm</p> <p>23 going to ask you a very general question, then</p> <p>24 we're going to get into the specifics of</p> <p>25 treatment.</p>
<p>1 George Washington University. And then I did my 2 neurosurgery training at the Mayo Clinic, and 3 then I did some time for an intra-residency 4 fellowship at the University of Pittsburgh 5 Department of Neurosurgery.</p> <p>6 Q I may have already asked you this. How long</p> <p>7 have you been employed as a neurosurgeon?</p> <p>8 A I've been practicing neurosurgery since I 9 graduated from my residency program in 2001.</p> <p>10 Q Give us some perspective as to your average week</p> <p>11 or your average month, how often are you -- do</p> <p>12 you have surgery days versus clinic days, and</p> <p>13 how many surgeries would you say you perform on</p> <p>14 an average week?</p> <p>15 A Yeah. So my practice is approximately 16 50 percent surgery, 50 percent clinic. So I 17 will spend between two to three days in the OR 18 per week, and then alternate weeks I would be 19 two to three days in the clinic. The average 20 number of surgeries I do varies from 21 year-to-year. There were years where I was 22 doing 10 to 12 surgeries a week. Now it's 23 closer to 6 to 8 per week.</p> <p>24 Q Do you maintain privileges at any hospitals and,</p> <p>25 if so, where?</p>	<p>Page 7</p> <p>1 What are the injuries that Ms. Gard</p> <p>2 sustained in the accident that ultimately led to</p> <p>3 the cervical fusion that you performed?</p> <p>4 A So she developed neck pain after the car 5 accident, and -- and she ultimately ended up 6 having both non-surgical and surgical treatment 7 for the neck pain.</p> <p>8 Q What I've shown you -- or showing you here,</p> <p>9 Doctor, has been marked as Exhibit 3. What I</p> <p>10 did was take out some records from what will be</p> <p>11 Plaintiff's Exhibit No. 1, which is the</p> <p>12 certified medical records, and I took out</p> <p>13 records that I think you and I will talk about</p> <p>14 today. I highlighted some areas that I think</p> <p>15 may be a topic of discussion, and I also Bates</p> <p>16 stamped in the lower right-hand corner for the</p> <p>17 sake of our discussion today, so we don't have</p> <p>18 to flip around as much.</p> <p>19 With that being said, I would like for</p> <p>20 you to take a look at the first Bates stamped</p> <p>21 page number 1.</p> <p>22 Do you have that in front of you?</p> <p>23 A I do.</p> <p>24 Q All right. And this appears to be an urgent</p> <p>25 care clinic from the date of the accident,</p>

Page 10	Page 12
<p>1 March 27th of 17.</p> <p>2 Can you tell from this document,</p> <p>3 Doctor, what pain complaints Ms. Gard was</p> <p>4 reporting at that time?</p> <p>5 A Yeah. She said that she was having bilateral</p> <p>6 shoulder pain, as well as pain on the left side</p> <p>7 of her head, and then she said additionally pain</p> <p>8 included neck pain.</p> <p>9 Q If you can flip the page to Bates stamp number 2</p> <p>10 there, this appears to be dated March 30th of</p> <p>11 '17. The note is with a Dr. Amy Swift-Johnson.</p> <p>12 Do you know her?</p> <p>13 A Not personally.</p> <p>14 Q All right. Can you explain the symptoms that</p> <p>15 she appeared she was having at that visit,</p> <p>16 please.</p> <p>17 A The doctor reports in here that she was having</p> <p>18 continued bilateral neck pain, which is neck</p> <p>19 pain on both sides. It was worse on the right</p> <p>20 side. She was having pain also going into the</p> <p>21 shoulder blades and going down the back.</p> <p>22 Q Okay. Would it be reasonable at that point</p> <p>23 based on what you know, Doctor, for Ms. Gard to</p> <p>24 undergo a series of physical therapy?</p> <p>25 A Yes. It would be very reasonable.</p>	<p>1 Q Okay. What I would like to draw your attention</p> <p>2 to now is number 10 on Exhibit 3. This appears</p> <p>3 to be date of service from June of 2018.</p> <p>4 Do you see that?</p> <p>5 A I do.</p> <p>6 Q And under the operative procedure it says</p> <p>7 "medial branch nerves."</p> <p>8 Can you tell from this what procedure</p> <p>9 it is that Dr. Ong is performing here?</p> <p>10 A Yeah. He's doing a block of the pain nerve</p> <p>11 endings or fibers that go to the facet joints at</p> <p>12 C4-5, C5-6, and so he calls it a medial branch</p> <p>13 block.</p> <p>14 Q In your opinion what is the objective of such a</p> <p>15 procedure?</p> <p>16 A The objective is to identify the location of the</p> <p>17 neck pain. He makes a determination of where</p> <p>18 the neck pain is based on exam, history, imaging</p> <p>19 review, and then with that he'll decide where he</p> <p>20 thinks the neck pain is coming from. He'll want</p> <p>21 to have some sort of objective evidence to say</p> <p>22 that that is where the pain is coming from, so</p> <p>23 he'll do a block under X-ray to make sure that,</p> <p>24 in fact, her pain is coming from that area.</p> <p>25 Q Flip to Bates stamp number 11 there. I have</p>
Page 11	Page 13
<p>1 Q All right. What I would like to do is show you</p> <p>2 Exhibit No. 4. We're going to go back to 3, but</p> <p>3 let's just switch to 4. All right.</p> <p>4 Do you see that note, Doctor?</p> <p>5 A Yes.</p> <p>6 Q And what's the date on that note?</p> <p>7 A April 30th, 2018.</p> <p>8 Q All right. I think I went out of order just a</p> <p>9 bit. In any event, we're going to get to --</p> <p>10 well, no. Let's stick on Exhibit No. 4.</p> <p>11 What is the referral at that point</p> <p>12 from the -- from the physician, based on</p> <p>13 Exhibit 4?</p> <p>14 A Yeah. So in this note she recommends or says</p> <p>15 that she can follow up with pain management.</p> <p>16 Q This is missing some pages. That's okay.</p> <p>17 You're aware of Dr. Ong?</p> <p>18 A Yes.</p> <p>19 Q Who is Dr. Ong, and how do you know him?</p> <p>20 A So Dr. Ong is a physician who practices in pain</p> <p>21 management. He works out of Aurora Lakeland</p> <p>22 Hospital.</p> <p>23 Q Do you have a referral relationship with</p> <p>24 Dr. Ong?</p> <p>25 A Yes. Yes, we do.</p>	<p>1 highlighted that Dr. Ong appears to be an</p> <p>2 interventional pain management doctor.</p> <p>3 Is that your understanding?</p> <p>4 A That is correct.</p> <p>5 Q Is it common in your experience, Doctor, for</p> <p>6 someone who has neck pain who undergoes a series</p> <p>7 of physical therapy and does not get relief to</p> <p>8 then be referred to a pain management</p> <p>9 specialist?</p> <p>10 A It's very common.</p> <p>11 Q What I would like to do now, at this point I</p> <p>12 think we're starting to get into some of your</p> <p>13 notes. Bates stamp number 12 there, Doctor, if</p> <p>14 you could. The date on that is July 12 of 2018.</p> <p>15 Do you see that?</p> <p>16 A I do.</p> <p>17 Q Do you believe this to be the first office visit</p> <p>18 that you had with Ms. Gard?</p> <p>19 A I believe so.</p> <p>20 Q And what were some of the problems, if any, that</p> <p>21 she was explaining to you at that point?</p> <p>22 A The main issue is she was having chronic neck</p> <p>23 pain.</p> <p>24 Q If you flip the page to Bates stamp 13 there,</p> <p>25 does this discuss some of the facet joint</p>

Page 14	Page 16
<p>1 injections that she was having and talk about 2 the relief that she was receiving, and, if so, 3 can you explain that, please?</p> <p>4 A Yeah. So she had the medial branch block, and 5 she reported she had at least 50 percent pain 6 relief.</p>	<p>1 date of service from August 9th of 2018, and it 2 looks like another operative note of sorts from 3 Dr. Ong.</p>
<p>7 Q Can you explain in your experience, Doctor, 8 the -- how typical is that, for someone to get 9 50 percent relief? Is that typical? Atypical? 10 Can you talk about that?</p>	<p>4 Would you agree with that?</p>
<p>11 A I mean, if they're able to identify the proper 12 location and if the person is a reasonably 13 responding individual -- because some people 14 just don't respond to injections -- they should 15 at least get 50 percent, and it's very 16 reasonable to expect that.</p>	<p>5 A Yes.</p> <p>6 Q And from this document could you tell what 7 procedure we're talking about here?</p>
<p>17 Q If you could now flip to page 17, which I think 18 is the last or second-to-last page, maybe, of 19 your visit.</p> <p>20 What was the plan or course of action 21 that you establish with Ms. Gard at your first 22 visit?</p>	<p>8 A He says he's doing medial branch blocks.</p> <p>9 Q Is it common to -- for a patient to undergo 10 multiple medial branch blocks?</p> <p>11 A In fact, it is, because you want to be able to 12 have reproducibility to finding the location of 13 pain gene- -- to find the pain generator. It is 14 possible if you do it only once that you may 15 have just mistakenly thought that that's the 16 level, because sometimes the medication could 17 spread, sometimes you could be off. I mean, 18 there is so many different variables. So by 19 repeating it and getting the same result, it 20 increases the confidence of your original 21 findings.</p>
<p>22 Q Okay. If you now flip to Bates stamp 20, and 23 this appears to be another office visit from you 24 dated August 22nd of 2018.</p>	<p>22 Q Would you agree with that?</p>
<p>23 A So on our first visit we wanted her to maximize 24 her therapy with Dr. Ong, her treatments with 25 Dr. Ong. She had gotten relief with the facet</p>	<p>23 Q Okay. If you now flip to Bates stamp 20, and 24 this appears to be another office visit from you 25 dated August 22nd of 2018.</p>
Page 15	Page 17
<p>1 injections. Certainly it would have been 2 reasonable for her to go back again. Because I 3 think Dr. Ong and her had talked about a second 4 round.</p>	<p>1 A Yes.</p> <p>2 Q Flip the page to Bates stamp 21 there. I take 3 this to be part of the history and discussion 4 that you're having with Ms. Gard at this visit.</p>
<p>5 I know that this was potentially 6 leading toward a more permanent solution called 7 radiofrequency ablation, which is the permanent 8 version of the medial branch block, which is a 9 more temporary version, and I had steered her in 10 that direction. I felt that that was more than 11 appropriate for her to try to find the least 12 invasive method for pain relief.</p>	<p>5 Q Is that a fair statement?</p> <p>6 A Yes, it is.</p> <p>7 Q And what was your advice or what was the plan or 8 course of action that you establish with 9 Ms. Gard at that time?</p>
<p>13 Q It also talks on number two here for the plan is 14 to continue with Aleve.</p>	<p>10 A Yeah. So at that time she says her pain is a 11 little bit more tolerable. She said she didn't 12 have neck pain before the accident. She wanted 13 to know what would be a long-term option down 14 the road, and I think we had talked about 15 surgery. She wasn't interested in surgery at 16 that moment, and she thought that she could 17 continue to manage her pain without open 18 surgery. And we certainly were fine with that. 19 We, in fact, always support that whenever 20 possible.</p>
<p>15 Would that be a -- something that -- 16 well, is that something you recommended at that 17 time that she continue?</p>	<p>21 Q And perhaps my question would have been better 22 served after we looked at page 25, so I'm going 23 to have you briefly read the bottom highlighted 24 part there, and can you let us know when you've 25 had a chance to read that.</p>
<p>18 A Yeah. I mean, she was taking that, and then we 19 said, "You know what, that sounds great. You 20 know, if you're getting relief from that, let's 21 continue that." And I also said, you know, she 22 could try other therapies like Lidoderm patches 23 and so forth.</p>	<p>21 Q And perhaps my question would have been better 22 served after we looked at page 25, so I'm going 23 to have you briefly read the bottom highlighted 24 part there, and can you let us know when you've 25 had a chance to read that.</p>
<p>24 Q If you could now turn to the next page, which is 25 Bates stamped 18, Doctor. This appears to be a</p>	<p>21 Q And perhaps my question would have been better 22 served after we looked at page 25, so I'm going 23 to have you briefly read the bottom highlighted 24 part there, and can you let us know when you've 25 had a chance to read that.</p>

Page 18	Page 20
<p>1 A Okay. So in this paragraph we had a discussion 2 about the possibility of future surgery. And 3 even though she was managing -- and certainly, 4 again, we are supportive of that. It seemed 5 like she was always having breakthrough pain, 6 and I felt that at some point surgery may be 7 indicated.</p> <p>8 Q But at this time in August of 2018, it was not 9 yet recommended by you, is that a fair 10 statement?</p> <p>11 A I think at that point I didn't feel that she had 12 to have surgery. In her mind she wanted to 13 maximize everything nonsurgical, and I think 14 that there is so many factors that come into 15 making a surgical recommendation. When it's for 16 pain specifically, the patient has to be in that 17 mindset as well, and I think she wasn't.</p> <p>18 And so we really knew that it was not 19 critical that she have surgery that day. It 20 wasn't like she was, you know, in the midst of 21 being paralyzed. We felt that since this would 22 be for pain that most likely she will need 23 surgery down the road, but that -- the timing of 24 that would have to be based on what she felt 25 comfortable with.</p>	<p>1 November 15 of 2018. 2 Do you see that?</p> <p>3 A Yes.</p> <p>4 Q It appears that at least per this document that 5 it says "The patient has underlying facet joint 6 arthropathy."</p> <p>7 Can you explain what that means?</p> <p>8 A Yeah. So it just means there is disease or some 9 damage to the facet joint.</p> <p>10 Q What is the procedure that is indicated here on 11 Bates stamp 33?</p> <p>12 A Yeah. So this procedure he's describing is 13 radiofrequency ablation of the nerve endings 14 around the -- at or around the facet joints to 15 alleviate pain.</p> <p>16 Q I've heard radiofrequency ablation is a nerve 17 burning procedure. Is there some correlation 18 there, or am I making that up?</p> <p>19 A No. So, unfortunately, it's called nerve 20 burning. You're technically not burning any 21 nerves. You're destroying nerve endings, which 22 are pain receptors which are connected through 23 tiny filaments to the actual large nerve bundle. 24 So the large nerve bundle itself is not damaged.</p> <p>25 Q Gotcha. If you could then flip to Bates stamp</p>
Page 19	Page 21
<p>1 Q At that point in your opinion was it reasonable 2 for her to push off the surgery and try other 3 conservative --</p> <p>4 A Absolutely.</p> <p>5 Q -- remedies?</p> <p>6 A Absolutely. Yes. Absolutely.</p> <p>7 Q It appears here under the plan that you 8 recommend that she continue with Dr. Ong. 9 Is that a fair statement?</p> <p>10 A Yes.</p> <p>11 Q And then also order -- in plan three there it 12 looks like order another CT of the cervical 13 spine. 14 Is that to see if there is any 15 progression of her problem?</p> <p>16 A Yeah. So one of the things that we can see in 17 CAT scans that we can't always see on MRI is we 18 can see damage that MRI won't show. So if there 19 is facet damage, which is the area that 20 Dr. Ong was injecting, we can sometimes see 21 black streaks in the facet joints, and that's 22 what I was looking for.</p> <p>23 Q Gotcha. If we could then turn to page Bates 24 stamp 33, please. This appears to be an 25 operative note of Dr. Ong again dated</p>	<p>1 37, please. This is a date of service from 2 November 29 of 2018. It looks like another 3 radiofrequency ablation, although this one 4 targets the left side of C4, C5, and C6, whereas 5 the prior one was the right side. 6 Is that common for there to be two of 7 those procedures within a two-week time span, 8 one targeting each side?</p> <p>9 A Yeah. And this is probably based on Dr. Ong's 10 experience. He probably felt that he wanted to 11 try one side, see how effective it was, and then 12 go to the other side.</p> <p>13 Q Are we still within the realm of what you would 14 call a reasonable course of care for Ms. Gard, 15 based on the injuries that you observed?</p> <p>16 A Absolutely.</p> <p>17 Q If we could now turn to Bates stamp number 39, 18 please. This appears to be another office visit 19 from your office dated December 5 of 2018. 20 Would you agree with that?</p> <p>21 A I agree.</p> <p>22 Q And then the stuff I want to talk about is on 23 Bates stamp 43, if you could flip to that, and 24 there is some stuff I highlighted on page 43 and 25 44.</p>

Page 22	Page 24
<p>1 Can you explain the recommendations 2 that you made to Ms. Gard at that time, please. 3 Well, let me back up. Let me withdraw 4 the question.</p>	<p>1 30 percent. 2 I think we talked about it a little 3 bit, but is that a common phenomenon you see in 4 your patients that have these types of 5 procedures?</p>
<p>5 The first question I want to ask you 6 is what was the discussion you were having with 7 Ms. Gard at that time based on the feedback you 8 were getting from her with the conservative 9 treatment she had received up to that point?</p>	<p>6 A Yeah. I mean, there is certainly a temporary 7 nature to all these needle procedures and the 8 radiofrequency. I mean, it's possible that it 9 could have lasted longer. I mean, it's not 10 unheard of for it to last several months to a 11 year, and it's certainly possible that it only 12 lasts a few weeks.</p>
<p>13 Q Is it common for someone to have temporary 14 relief from those radiofrequency ablations?</p>	<p>13 Q The last sentence that I highlighted, it says 14 "Continues to have neck pain radiating to both 15 shoulders."</p>
<p>15 A Yeah. Absolutely. We can't promise how long 16 those will last. You know, sometimes they last 17 weeks, sometimes they last months, and anywhere 18 in between. So that's very much variable on the 19 person.</p>	<p>16 I understand that for you to evaluate 17 what that really means you would want to see 18 some imaging, but from a clinical standpoint 19 with that comment there with her neck pain 20 radiating to both shoulders, what does -- what 21 does that indicate to you, if anything?</p>
<p>20 Q The next page there I have one sentence 21 highlighted. It appears now that the topic of a 22 surgical procedure is starting to pop up.</p>	<p>22 A It tells me that the area that was hurting from 23 the very beginning is still continuing to hurt 24 her at this point.</p>
<p>23 Is there any correlation between the 24 timing of this, meaning you're now talking to 25 her about surgery after she's done the</p>	<p>25 Q The next document is -- that I would like to</p>
Page 23	Page 25
<p>1 conservative measures? Is that typical or 2 atypical?</p>	<p>1 draw your attention to, Doctor, is Bates stamp 2 number 48, please. This appears to be an office 3 visit from February 27 of 2019.</p>
<p>3 A It's very typical when the patient asks or if 4 the patient is concerned about long-term 5 management. And there was several issues that 6 came up. You know, she wanted to know what -- 7 would she have to do radiofrequency over and 8 over, and I said certainly that would be 9 possible. She was concerned about, you know, 10 would surgery give her that permanency, and I 11 said yes. She wanted to know if there were any 12 risks, and I said absolutely.</p>	<p>4 Would you agree with that?</p>
<p>13 And so we kind of had all the 14 different things, and it took multiple 15 conversations to just finally sort of come to 16 the conclusion that surgery was the thing that 17 she wanted to pursue.</p>	<p>5 A I agree. 6 Q And then if you turn to Bates stamp number 53 on 7 that, I highlighted some things, and it appears 8 that from my recording of this page here that 9 the option of surgery or the recommendation of 10 surgery, you're getting closer to that.</p>
<p>18 Q Gotcha. If you can flip the page to page 45. 19 This is an office visit from December 19 of 2018 20 with Dr. Ong.</p>	<p>11 Can you comment on that?</p>
<p>21 Would you agree with that?</p>	<p>12 A Yeah. I mean, I think at this point, you know, 13 she says she still has persistent symptoms.</p>
<p>22 A I agree. 23 Q It appears here that -- per this record that 24 Ms. Gard obtained initially 50 percent pain 25 relief from the procedure. Now she was down to</p>	<p>14 Q And I may interrupt. What were the symptoms per 15 this note that she was reporting at that time? 16 A Well, pain in the neck going into the shoulder, 17 into the trapezius muscles, which is just 18 muscles between the shoulder and the neck, and 19 then pain going into the shoulder blade. She 20 feels that it just feels uncomfortable with just 21 normal daily activities. So those were the main 22 symptoms.</p>
<p>23 Q I note here from my reading that the MRI appears 24 that she has significant disease at C5 and C6. 25 What do you mean by that?</p>	

Page 26

Page 28

1 A I mean there is -- there is an -- there is --
 2 the disc at C5-6 is abnormal, and based on where
 3 the radiofrequency was, based on what the MRI
 4 was, we felt that C5-6 was our target.

5 Q Okay. The next note is page 54, if you can turn
 6 to that. It appears that office visit is
 7 October 30th of 2019.

8 Do you see that?

9 A Yes.

10 Q Flip the page here to page 56. It appears
 11 now -- we're in October of 2019 -- that you are
 12 now making the official recommendation of a
 13 surgery.

14 Can you please confirm that's true,
 15 and, if so, what surgery were you recommending
 16 and why?

17 A Yeah. We're recommending -- so we were
 18 recommending a fusion surgery at the C5-6. We
 19 recommended it from the front.

20 Q Why?

21 A The -- the disc at C5-6 appeared abnormal. We
 22 can do a fusion at 5-6 from the front and get
 23 the most stabilization of the C5-6 segment. We
 24 could certainly approach it from the back of the
 25 spine, which is the direction Dr. Ong went in

1 we're -- we encourage every patient when we
 2 discuss surgery to -- you know, just to take
 3 some time out of the -- away from the doctor's
 4 office and think it through. We, in fact, tell
 5 every patient to do that.

6 Q Okay. That brings us to page 58, if you can
 7 flip to 58, please. That appears to be a visit
 8 from you of November 20th of 2019.

9 Would you agree with that?

10 A I agree.

11 Q If you flip to the page 60 of that, it appears
 12 now the plan is to actually go through with the
 13 surgery.

14 Am I reading this correctly?

15 A That is correct.

16 Q And my guess is that this indicates Ms. Gard
 17 thought about it for a period of time and
 18 decided to call back and wanted to schedule the
 19 surgery.

20 Do I have that right?

21 A That is correct.

22 Q All right. And then the next one that I would
 23 like for you to turn your attention to is Bates
 24 stamp number 66. That appears to be your
 25 operative note of December 24th of 2019.

Page 29

1 with the needles. However, you have to disrupt
 2 more muscle tissue, and the recovery is longer.

3 So often when a fusion needs to be
 4 done and a choice -- you have a choice between
 5 the front or the back, most surgeons opt for the
 6 front because the recovery is faster and you
 7 seem -- you can get a little bit stronger
 8 stabilization.

9 Q It appears from page 56 here that prior to
 10 making that recommendation, you obtained some
 11 more diagnostic imaging in the form of an MRI.

12 Is that true, and why did you do that
 13 at that time?

14 A I don't remember when her prior MRI was, but
 15 typically we like to have a repeat MRI, if it's
 16 been many, many months from the prior imaging,
 17 just to see if there is any changes.

18 Q And it appears that from page 56 here that this
 19 was a situation where Ms. Gard didn't right away
 20 say she wanted to have the surgery. To the
 21 contrary, it looked like she wanted to just
 22 think about it for a little bit.

23 Is that true, and is that a common
 24 phenomenon you see?

25 A Absolutely. It's super common. In fact,

1 Am I seeing that correctly?

2 A That is correct.

3 Q And using these documents and your memory and
 4 your expertise, can you explain with as much
 5 detail as you can the surgery that you performed
 6 on Ms. Gard.

7 A Yeah. So the procedure is called an anterior
 8 cervical discectomy and fusion. What we do is,
 9 after the patient is asleep on the table, we
 10 make an incision in the front of the neck.
 11 Using X-ray we identify the C5-6 level. We'll
 12 put small distraction pins into the body. It's
 13 just to open up the space a little bit to have
 14 room to work in. We'll bring in a microscope so
 15 we're able to magnify everything that we see.

16 And using instruments -- they're
 17 called curettes -- we just curette out all the
 18 disc space. We'll go to the back of the disc,
 19 we'll identify any nerves that are there and
 20 just check to see if the nerves are being
 21 pinched, and we'll free them.

22 Once that's done, the bone where the
 23 disc came from, we'll rough it up until we just
 24 get tiny bits of bleeding so that it will be
 25 likely to fuse.

	Page 30		Page 32
1	We'll put a spacer in there, and the	1	cylinder -- on top of the C5 and C6 bones, we'll
2	spacer can be anything the surgeon chooses,	2	put a small plate. And the plate is made of
3	whatever works and whatever the patient prefers.	3	titanium metal, and then there will be little
4	Often we'll fill it either with the patient's	4	holes in the plate for screws to go in and
5	own bone or something called allograft, which is	5	anchor the plate to the bone.
6	cadaver bone.	6	And typically these screws are -- we
7	What I typically do is I do a mixture.	7	always use millimeter measurements, so they're,
8	I'll take bone from the surgery and then bone	8	like, between 12 to 15 millimeters in length.
9	from a cadaver that's commercially available.	9	And 25 millimeters is an inch, just to give you
10	We'll put it into the spacer, put it in there,	10	reference.
11	and then we'll put a small plate that anchors	11	And so we'll put these screws in.
12	everything together, and the plate is screwed	12	They'll go into the bone, they'll screw in,
13	into the bones.	13	they'll lock the plate down, and that will
14	Q So this was at C5 and C6, and I want to see if I	14	provide a bracing. It will internally brace the
15	have that correctly. This involves an incision	15	bones together. Similar to someone who is
16	into the front of the neck.	16	wearing an external collar or brace, this is an
17	Can you use your finger there, kind	17	internal brace that will hold it all together.
18	of --	18	Q Am I correct in assuming that that bracing
19	A Yeah.	19	promotes the idea of lack of -- or non-movement
20	Q -- you point to where the incision is.	20	so that the bones can naturally fuse together
21	A So most surgeons will make an incision on the	21	better?
22	right side, so we'll find the midline midpoint	22	A Absolutely. Yeah. So you want those two
23	at the neck -- in men, 5-6 is not far from the	23	bones -- the C5 and C6 bones -- not to move, and
24	Adam's apple -- and -- and we'll just go to the	24	then the healing will occur. Once it fuses, the
25	right of that, and so we'll make a linear	25	body will use the fusion of bone to prevent any
	Page 31		Page 33
1	incision, like, right here.	1	further movement, and then the plate actually
2	Q And am I correct in hearing you that one of the	2	just becomes superfluous at some point.
3	first things you do -- I'm not going to say it's	3	Q Did she tolerate the surgery okay?
4	the first, but -- is you identify the damaged	4	A Yes.
5	disc, and you remove that disc?	5	Q And then I have the next note here, page 69 --
6	A Yes.	6	do you see that? -- September 2 of 2020?
7	Q And then you fill that space with either cadaver	7	A Yes.
8	bone or the patient's actual bone; is that	8	Q And this is a post-op visit, and I think on
9	accurate?	9	page 71 there is some comment that I would like
10	A Correct. And we'll put that inside a structural	10	for you to talk about. Yeah. It goes to the
11	spacer that's usually like a small little	11	improvement noted by the patient at that time.
12	cylinder or small little box.	12	Can you tell the Court here, based on
13	Q And correct me if I'm wrong, but I'm going to	13	this note and Ms. Gard's perception, what she
14	assume the idea behind this is once you remove	14	felt -- how much she felt she improved from the
15	that damaged disc and replace it with bone, the	15	surgery?
16	idea is the body is going to naturally fuse	16	A Yeah. So at this point she says she's about
17	together, those bones will fuse together	17	20 percent better. You know, and we went
18	naturally; is that right?	18	through the questioning in every different way,
19	A That is correct.	19	and that was the number she came up with.
20	Q Are there any plates and screws involved in	20	Q All right. One thing I skipped over, on page 67
21	this, or no?	21	you talk about the risks of the surgery.
22	A Yes. So --	22	What are the known, verifiable risk
23	Q Can you describe that, please.	23	factors for the type of surgery Ms. Gard had?
24	A Yeah. So what we'll do is after we put the	24	A I mean, the risks are basically neurologic
25	interbody -- which is a box or a little	25	injury, injury to the nerves, to the spinal

	Page 34		Page 36
1	cord. There can be bleeding. There can be a	1	these, do these appear to you to be physical
2	spinal fluid leak. There can be injury to the	2	therapy records pertaining to Ms. Gard from
3	soft tissue structures in the neck, that	3	various Aurora facilities?
4	includes the vein, the artery that's there.	4	A Yes.
5	There is other nerves in that area as well.	5	Q And, again, I'll represent to you this physical
6	There is the trachea, the esophagus, the	6	therapy time frame was from roughly April of
7	thyroid. I mean, all these structures are right	7	2017 extending into early 2018.
8	there, and certainly they're at risk for injury.	8	With that representation, would that
9	There can be a risk of bleeding after	9	be a reasonable time period for Ms. Gard to
10	the surgery where you would have to go back in	10	undergo physical therapy?
11	and remove the blood clot. And usually you see	11	A Absolutely.
12	that within the first day -- day of the surgery.	12	Q The treatment that we have gone over today from
13	Infection certainly is a risk. There is a risk	13	the ER -- or excuse me -- the urgent care, the
14	that she doesn't fuse, and the metal plate I put	14	primary doctor, physical therapy, Dr. Ong, and
15	in can break. So these are the big risks	15	then the visits with you, do you believe all of
16	specific to the surgery.	16	that treatment to be reasonable and necessary to
17	And then there is general risks. You	17	address the injuries that Ms. Gard sustained in
18	know, she could have a heart attack. She could	18	this March 24th of 2017 accident?
19	have a blood clot in the leg that can go to the	19	A Absolutely. It's -- it's the standard of care.
20	lung. She can get pneumonia. You know, all	20	Q All right. Next I want to draw your attention
21	these other general risks.	21	to Exhibit 6.
22	Q Is it also a risk of this surgery that it may	22	Have you had a chance to review this
23	not work to the patient's satisfaction, meaning	23	document prior to today's deposition?
24	the patient may not get the relief that he or	24	A Yes.
25	she had hoped for?	25	Q Before we get into that specifically, I want to
	Page 35		Page 37
1	A That's always a risk. Absolutely. And I think	1	get a little background.
2	that with every patient we're very clear on that	2	You are a medical doctor, you are not
3	and we just say, you know, we feel that	3	necessarily a billing expert, you have people in
4	statistically this is what should happen, but I	4	your office to do that for you; is that correct?
5	said, you know, I can never guarantee it. And I	5	A That is correct.
6	think with Sheila, you know, as you can see, we	6	Q Are you generally aware of the various costs for
7	took a slow train to surgery. You know, we	7	various procedures that your patients undergo?
8	never ever said to her, "You've got to choose	8	A In general, yeah. I mean, never the specific
9	now" or "Let's just jump to surgery." We	9	exact amounts, but I have a general idea.
10	purposely take a slow train because this is a	10	Q All right. What I would like to do, then, is
11	very thoughtful process.	11	draw your attention to Exhibit 6, and I'll
12	Q Those risk factors that we just described there	12	represent to you that this is a graph that my
13	in the past couple minutes, are those risk	13	office made based upon the actual certified
14	factors that were explained to Ms. Gard?	14	medical bills that will be part of Exhibit 2 at
15	A Yes.	15	trial.
16	Q Prior to surgery?	16	With that background and that
17	A Yes.	17	representation, I would like to draw your
18	Q All right. A couple things that I want to go	18	attention to the left-hand column of this
19	over, Doctor. I talked about the physical	19	document. How this document works here, it's
20	therapy records, but I didn't give you a chance	20	two pages, and the first column on the left-hand
21	to go -- to look through those, and nor did I go	21	side of page one of Exhibit 6 then goes onto the
22	over those in any great detail. I would like to	22	second page of Exhibit 6, and it runs a total
23	turn your attention to Exhibit 5.	23	there.
24	I don't want you to go through these,	24	Do you understand what I'm getting at
25	but if you could just generally breeze through	25	Doctor?

		Page 38	Page 40
1	A I do. I do.		
2	Q Okay. And I would like for you to just briefly look through those charges on the left-hand column there, both page one and two. It includes urgent care, facet joint prices, physical therapy, and some imaging.		1 stay relative to the surgery you performed?
3			2 A I do.
4			3 Q And the last topic of discussion with Exhibit 6
5			4 here are your charges, and that's on the top
6			5 right of page 1 of Exhibit 6. It details office
7			6 visits and then eventually a surgeons' charge
	Do you see that, Doctor?		7 and then a couple more office visits.
8	A I do.		8 Do you see that?
9	Q And the bottom the total there is \$80,878.92.		9 A Yes, I do.
10	Do you see that?		10 Q And the total there is \$103,127.
11	A I do.		11 Do you see that?
12	Q Do you agree that those are generally reasonable charges for those procedures, Doctor?		12 A Yes.
13			13 Q And do you believe your charges for the services
14	A Yeah. I mean, I realize that, you know, these are large numbers, but that is in line with what I've seen with -- from other centers, other practices, so that's well within the normal range.		14 you performed on Ms. Gard are reasonable in
15			15 nature?
16			16 A I do.
17			17 Q Okay. Doctor, you understand that various
18			18 providers can charge various different price
19	Q All right. The same questions I'm going to have with respect to a couple different graphs here.		19 tags for the same surgeries?
20			20 A Yes.
21	Do you see Wisconsin Radiology, do you see that segment there?		21 Q And is that, in fact, a common phenomenon to
22			22 your knowledge, that various neurosurgeons in
23	A I do.		23 the community may charge different prices for
24	Q Do you see the Metropolitan Anesthesiologists?		24 same or similar services?
25	A I do.		25 A Yeah. I mean, I think the neurosurgeons
		Page 39	Page 41
1	Q Do you see the Columbia St. Mary's charges there?		1 generally don't talk to each other about
2			2 pricing. I mean, to some degree we can't
3	A I do.		3 because there would be a collusion issue. But I
4	Q I'm going to assume that Wisconsin Radiology and		4 think that everyone tries to charge what they
5	Metropolitan Anesthesiologists are various		5 believe a fair price based on their practice
6	anesthesiology or radiology groups.		6 experience and the services they offer.
7	Would you agree with that?		7 MR. KNOBLOCH: Okay. At this point I
8	A Yes.		8 would like to move into evidence Exhibit 3, 4,
9	Q And those charges seem to be about -- well,		9 5, 6, 7, and 8.
10	exactly \$76 and \$10,868.		10 Any objection?
11	Do you see those numbers?		11 MR. PAWLAK: Yeah. I would like to
12	A I do.		12 object until I have an opportunity to
13	Q Do you agree that those are generally reasonable		13 cross-examine him about these exhibits, and then
14	prices for those services?		14 we can take that up afterwards.
15	A I agree.		15 MR. KNOBLOCH: Okay.
16	Q The Columbia St. Mary's, that indicates it's from the surgery and hospital stay. Those dates correlate with the dates we just talked about for the fusion surgery, so I'll call these the facility charge, and that facility charge is \$34,822.59.		16 BY MR. KNOBLOCH:
17			17 Q Doctor, have all of your opinions today been to
18			18 a reasonable degree of medical certainty?
19			19 A Yes.
20			20 MR. KNOBLOCH: Subject to moving these
21			21 into evidence, I have no further questions for
22	Do you see that?		22 this doctor.
23	A I do.		23 MR. PAWLAK: Thank you.
24	Q Do you agree that that is a reasonable charge for the surgery facility charge and the hospital		24 EXAMINATION
25			25

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1 BY MR. PAWLAK:	1 know, a lot of the charged amounts that are
2 Q Let's start with Exhibit 6, where we finished	2 submitted to insurance companies, we don't get
3 off here. Can you tell us why under the	3 paid this. So, you know, there is charged --
4 Metropolitan Anesthesiologists there are two	4 there is billed amounts, and then there is
5 identical itemizations for \$5,434?	5 whatever you get billed. And so, you know,
6 A I can't tell you that because I didn't generate	6 these numbers are generated by all practices.
7 the bill.	7 Everyone has their way of developing their
8 Q Okay.	8 numbers, and I'm telling you, relative to all
9 A Nor I did personally review the bill. All I	9 other charges, I would say this is reasonable.
10 have is the number in front of me.	10 BY MR. PAWLAK:
11 Q So really, although you testified you believe	11 Q Okay. So before we get to how you generate your
12 these were reasonable, you really have a	12 numbers -- that's a great segue -- let me go
13 complete lack of foundation here to comment	13 back to one more point.
14 whether these are reasonable prices?	14 So, for example, here, the hospital
15 MR. KNOBLOCH: Objection to form.	15 stay is at 34,822. You've testified that you
16 THE WITNESS: I don't have a detailed	16 believe that was reasonable; is that correct?
17 review of what the charges are. I know that	17 A Correct.
18 roughly in the market I think these are	18 Q What are you basing that upon?
19 approximately reasonable. If you said to me,	19 A Again, based on what I've heard other facilities
20 you know, "What is an anesthesiologist supposed	20 charge. You know, I've seen facilities charge
21 to charge?" I couldn't tell you, because I'm not	21 more than this, and so to me that seemed a
22 an anesthesiologist.	22 reasonable number. I mean, I wouldn't have been
23 BY MR. PAWLAK:	23 shocked -- shocked. I've seen Aurora charge
24 Q Okay. Exactly. Well, as you're looking at this	24 double this.
25 from whatever -- whatever basis that you're	25 Q Okay. So at what point would you be shocked?
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1 making, you're offering this opinion, when does	1 100,000? 150? A quarter million? What would
2 the anesthesiologist -- at what point does the	2 be unreasonable in your opinion, based upon your
3 anesthesiologist fee become unreasonable?	3 knowledge and experience in this area?
4 A I think you would have to ask an	4 A I mean, I think that, you know, certainly if
5 anesthesiologist.	5 they got to a number that was significantly
6 Q Okay. So then you would agree with me you	6 higher, so maybe over 100,000.
7 really have no basis to comment on whether or	7 Q Okay. So how do you set your fees?
8 not this anesthesiologist fee was reasonable?	8 A So our fees were set many, many years ago by my
9 MR. KNOBLOCH: Objection to form.	9 billing manager. So 20 years ago we started the
10 THE WITNESS: I think my basis is on,	10 practice and it was part of a larger group of
11 you know, approximately, it's a physician	11 neurosurgeons and they had their fees, and we
12 providing a service for X amount of period of	12 really couldn't share fee numbers. We were
13 time. You know, it's an approximate number, I	13 told, you know, "You have to set your fees."
14 could say that it's reasonable.	14 So I had a billing manager start, and
15 Because if you said to me, "What are	15 she -- she checked national fee numbers, and
16 they doing?" you know, I would say, "Yeah,	16 then she set my fees. And then every year --
17 they're keeping the patient alive, they're --	17 and this was 20 years ago, this is 2001, 2002,
18 they're accepting a risk." I mean, there is a	18 2003, roughly in there -- she gradually
19 lot of time investment, and they have to do	19 increased the fees based upon what insurance
20 postoperative care. I think that if you said to	20 companies allowed, based upon national trends,
21 me, you know, given the fact that in medicine	21 based on inflation.
22 what we charge, you know, they're going to	22 And just over the years she has, you
23 change about this number, I would say relative	23 know, roughly increased the fees, and she would
24 to everyone else, that seems reasonable.	24 say, "Hey, you know, Dr. Dagam, you've had the
25 Now, we have to also remember, you	25 same fees for the last three years. You know, I

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<p>1 think it's time we increase the fees a certain 2 percentage," and I said, "Okay." 3 And she goes, "You know, I think, you 4 know, the other neurosurgeons are increasing 5 their fees, I've talked to other doctors," so 6 she has increased the fees over 20 years, and 7 this is kind of where we ended up. 8 I would say if -- you know, my fee 9 numbers are based upon 20 years of practice, 20 10 years of experience, and the complexity of what 11 we do. We do complex spine cases. Spine cases 12 do generally charge more than other surgical 13 cases. Spine cases, they generate -- they have 14 higher RVU numbers. When you add them all up, 15 the RVU numbers are much larger. 16 So if you base it on -- per -- you 17 know, on the number of RV -- total RVUs, you 18 know, we're going to have a larger bill. We've 19 been around for 20 years. We have 20 years of 20 experience. So I think all that kind of comes 21 together. That's how we have generated our 22 charges. 23 Q Please define what RVU is. 24 A Relative value unit. Again, I'm not a billing 25 expert, but that's -- that's sort of the</p>	<p>1 A I don't know because I don't ask other surgeons 2 what their numbers are. 3 Q Okay. And have you ever heard, for example, of 4 charging -- so, for example, you know, 110 or 5 120 percent of what Medicare would pay for a 6 similar surgery? 7 A Could you repeat that. 8 Q Sure. Sure. You must be aware that Medicare 9 sets prices, reimbursement rates for surgery; 10 correct? 11 A Correct. 12 Q And I'm sure you've done similar surgeries here 13 today for Medicare? 14 A Correct. 15 Q And they usually -- I know doctors complain 16 about what Medicare pays? 17 A Yes. 18 Q All right. So if you were -- have you ever 19 heard in private practice, capitalism rules in 20 this country, we control what we want to charge 21 for ourselves? 22 A Yes. 23 Q Have you ever heard of doctors setting -- for 24 example, "I know what Medicare pays for this 25 surgery, I'm going to charge 125 or 150 percent</p>
Page 47	Page 49
<p>1 assigned value for any particular procedure you 2 do. So doing a cervical fusion, each different 3 part of the fusion has a value, a relative 4 value. And so we're doing, like, at least -- if 5 you look at the op. note, we're doing at least 6 three or four different things. 7 And I think -- and I don't know if 8 this fee also includes the assistant fee. I 9 don't know. I don't know if that includes that. 10 Q Just to give you a preview, I will be addressing 11 that issue, but I'm going to stick with this one 12 for the time being. 13 So what's your billing manager's name, 14 please? 15 A So my billing manager has changed. We've 16 changed this year because of COVID. So it was 17 originally Heidi Weber, but now it's 18 Rhonda Nessler. 19 Q So is Heidi no longer working for you? 20 A No. Because of COVID, our practice reduced, and 21 she wanted a bigger position, so she moved on. 22 Q So are you aware of where you are for charging 23 for spine-type surgeries within the Milwaukee 24 area? Are you high? You're low? You're in 25 between?</p>	<p>1 of what Medicare pays"? Have you ever done 2 anything like that to your knowledge? 3 A I think, yes, to some degree I have heard that, 4 where doctors will charge a multiple of what 5 Medicare will pay. So it's not typically 1.2, 6 1.3, but it will typically be 2 to 3 times or 7 even higher than that. 8 Q Okay. 9 A And that's what their -- and that would be what 10 their billed amount is. So, again, our billed 11 amounts are very different than what we get 12 paid, you know, because if we submit a bill -- 13 we'll submit the same charge to Medicare, but 14 we'll just get Medicare reimbursement numbers, 15 you know, et cetera. 16 Q Do you know whether you've been paid anything 17 for these surgeries? 18 A I would have to ask my billers, because I don't 19 know if I've been paid for this or not. 20 Q Okay. All right. So you don't know if your 21 surgery is -- your prices that you charge are 22 high/low for what you do, it's just based upon 23 20 years of cumulative surgery and your -- 24 Heidi Weber adjusting the rates over those -- 25 A Correct.</p>

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1 Q	-- 20 years?	1 that day?
2 A	Correct.	2 A I don't know the exact number, but it is broken
3 Q	Okay. All right. I'm going to give you what's	3 down into many components.
4	been marked as Exhibit No. 9. It's described as	4 Q Yeah. I mean -- and if you don't want to trust
5	a Patient History Detail for the neurological	5 my counting, feel free to count on your own. I
6	surgery that you did in this matter.	6 mean, I'm just trying to hit the ballpark here.
7	So Plaintiff's attorney submitted a	7 A Sure. Sure. I know it's a multiple. Yes.
8	document, Exhibit 6, which indicates your fees	8 Q All right. So -- and each of these codes -- for
9	were 103,127. The document which I have in	9 example, let's look at the first code, 63081.
10	front of you, which is broken down into	10 Are you familiar with that?
11	significant detail, indicates it's 101,527, so	11 A Yes.
12	relatively close in the grand scheme of things;	12 Q And what is that, if we can refer to it as one
13	correct?	13 or two words to give it a --
14 A	Correct.	14 A Yeah.
15 Q	All right. So you indicated earlier, you asked	15 Q -- title?
16	whether or not the fees reflected in Exhibit 6	16 A Yeah. It's called a corpectomy code.
17	actually detailed the work done -- I think you	17 Q Okay. So I looked through your report, and I
18	used the word "assistant" in the surgery	18 never found a mention of a corpectomy.
19	process?	19 Why is that?
20 A	Yes.	20 A I don't know if the -- are you talking about the
21 Q	And who was that assistant, and who is that	21 operative report?
22	person?	22 Q Yeah. Yeah.
23 A	Oh, yeah. So my physician assistant,	23 A I don't know where -- do you have a copy of it?
24	Beau Boedecker.	24 Q Well, I'll tell you what. I'm going to pull
25 Q	So on this sheet there is obviously	25 open -- we're still on the record here. I want
	Page 51	Page 53
1	abbreviations used, and there is a provider	1 to just, if you don't mind -- you -- let me do a
2	column, it's P-R-O-V.	2 little segue.
3	And you would agree that stands for	3 You previously testified in a
4	"provider"; right?	4 deposition conducted by me; is that correct?
5 A	Correct.	5 A I believe so.
6 Q	And there are names listed. Your name, of	6 Q Yes. And I have here the certified original
7	course, is in full, D-A-G-A-M, which is your	7 copy of that, which is still in the plastic, and
8	entire last name.	8 I'm going to open here today to use again so we
9	And then there is B-E-A-U-B, and whom	9 don't duplicate this multiple times.
10	does that remember to?	10 A Sorry. I was going through the wrong stack.
11 A	That refers to the physician assistant,	11 Q So I'm going to give to you what was previously
12	Beau Boedecker.	12 marked as Exhibit No. 1 -- this might be -- in
13 Q	All right. And then we have on the far left	13 that deposition which was conducted on
14	side here the codes for the surgical procedures;	14 October 13, 2021, here at your same office of
15	is that correct?	15 which we were present today. The -- your
16 A	Correct. Yes.	16 operative reports are in that exhibit pages 67
17 Q	And this is -- this is how typically billing	17 through 79.
18	works in America today. Every process you	18 Feel free to go to those pages and
19	perform has to have a code assigned to it, and	19 tell me if you mention anything called a
20	then you bill out for that?	20 corpectomy in there.
21 A	That is correct.	21 A Yeah. So I actually use the word
22 Q	So, for example, although we've been referring	22 "vertebrectomy," and that's basically the same
23	to this as one surgery, this thing is broken	23 thing.
24	down here into at least 17, 18-plus different	24 Q Okay. Is there any difference between a
25	components of that surgery that you performed	25 corpectomy and a vertebrectomy whatsoever?

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1 A In my -- for me, no.

2 Q Okay. Would there be some other practitioners
3 who might have a nuance on those meanings?

4 A There may be, but I don't know what that
5 different would be.

6 Q Okay. So you talk about the partial C5
7 vertebrectomy and partial C6 vertebrectomy; is
8 that correct?

9 A Correct.

10 Q Now, why was it important to note that the
11 partial C5 was a decompression of the spinal
12 cord of 55 percent and the partial C6
13 vertebrectomy -- vertebrectomy -- excuse me --
14 was a decompression of the spinal cord of
15 60 percent? What's the relevance and importance
16 of those points?

17 A Yeah. So that kind of goes back to my billing
18 manager. So when we were doing these reports,
19 she has said to me, "Be as detailed and specific
20 as you can." So it's not necessarily critical
21 in this particular case, and it doesn't have
22 necessarily a critical clinical application. It
23 was more of a billing person.

24 Because what my billing manager would
25 do is with other insurance companies they would

1 guidelines on it, so I said, "All right, well,"
2 I go, "I'm not going to say anything that
3 obviously I didn't do," and she goes, "Yeah,
4 absolutely not."

5 So when we go in there, we do what's
6 necessary and then we dictate it. You know, so
7 if we're taking out 50 percent, you know, we're
8 like, all right, well, you know, she says, you
9 know, just make it 51 percent, just go in there,
10 and so I -- I kind of had to do what was
11 necessary and then make this report have enough
12 detail for her to be able to use it as whatever
13 she needed to fight the insurance company on.

14 Q Is it also true that one of the nuances in the
15 distinction or the definition between corpectomy
16 and vertebrectomy is a corpectomy is over
17 50 percent --

18 A I don't --

19 Q -- by definition?

20 A Yeah, that I don't know. Yeah. To me
21 vertebrectomy and corpectomy are very much the
22 same.

23 Q So 63081 is we'll call it the corpectomy. And
24 what is your assistant's name again, please?

25 A Beau Boedecker.

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1 often just not want to pay any codes, and then
2 she would go back and say, "Well, Dr. Dagam very
3 clearly specified in this operative report."

4 So she -- she had a long conversation
5 with me one time. This was many years ago. She
6 said, "You know, the more detailed you are" --
7 because originally when doctors do operative
8 reports, we're kind of going through them
9 quickly, you know. I mean, if it was up to me,
10 this operative report would be, like, four
11 sentences. You know, I just -- I would
12 literally just give a very general description,
13 and then obviously, you know, if anything -- any
14 complication occurred, I would put that in
15 there.

16 But with her, she said, "Look, you
17 know, my job is hard enough, so I need you to be
18 crazy detailed," so that -- that was the reason
19 why we kind of go into that level of detail.

20 Q Are you aware that, in fact, if the -- if the
21 decompression of the spinal cord is less than
22 50 percent, you can't charge as much?

23 A I don't know if that's the case, but she told
24 me, "If you're going to do a partial, you know,
25 don't" -- I don't know, she gave me some

1 Q Beau Boedecker. His charge amount for that was
2 \$7,365; is that accurate?

3 A Yes.

4 Q And then we go down to the second cor- -- help
5 me with this, please -- corpectomy?

6 A Correct.

7 Q And that was performed by you; correct?

8 A Correct.

9 Q And you charged \$20,251 for that?

10 A Correct.

11 Q Are you three times better than he is? Three
12 times faster? What's the difference for the
13 prices?

14 A Well, we work together.

15 Q Okay.

16 A Yeah. So he -- he's assisting me under the
17 microscope. I'm working there. We're both
18 working together. And so I -- you know, we have
19 to do the corpectomy together.

20 Q Okay. So correct me if I'm wrong, but I
21 envision you being the -- since you're the
22 surgeon, I envision you doing all the cutting
23 and the placing, and he's helping you out and
24 assisting you in whatever way, shape, and form
25 that you would deem necessary; correct?

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1 A That's correct.
 2 Q So why do we split up this billing on the sheet?
 3 Why is this done? What's the story behind this?
 4 A Well --
 5 Q It looks as if he performed one set of the stuff
 6 and you performed the other?
 7 A I think this is billing convention. So I don't
 8 set billing convention. I didn't invent it, nor
 9 do I enforce it. This is billing convention.
 10 This is the way billing is done.
 11 If it was personally up to me, you
 12 know, I would say "This is what we did, pay me
 13 this amount," but this is how the system is set
 14 up, so that's why it's split up into all these
 15 different categories and there is charges for
 16 him, charges for me.
 17 Q Okay. Let me get back to that. So describe to
 18 me literally what mechanically goes on. I know
 19 you did it earlier. But for the corpectomy,
 20 what qualifies, what procedure, what did you do
 21 to be able -- entitled you folks to bill under
 22 63081 for the corpectomy?
 23 A Well, we go in, we identify the disc space,
 24 remove the disc material. We feel underneath
 25 the vertebral bone. We feel that it's a little

1 they're not familiar with the surgery, it's --
 2 they're useless, you know.
 3 So a brand new PA from PA school is no
 4 good. Beau, who has been in with -- who has
 5 been with me for, you know, hundreds of cases,
 6 hundreds, maybe thousands of cases, that's
 7 critical. His skill is critical. So, you know,
 8 maybe the numbers reflect that, you know, that
 9 experience, that information, the nuance.
 10 You know, it's kind of like having
 11 someone who really has played the violin really
 12 well as a first and second violin, and together
 13 you have a symphony. And I'm not a musician, so
 14 I'm just -- my metaphor might be horrible, but
 15 that's literally what's happening.
 16 Q Okay. Let's move on to the next one. 63082, do
 17 you know what that one is?
 18 A That's the other vertebrectomy code for the
 19 other, the C6.
 20 Q And can we assign a brief descriptor to that
 21 process?
 22 A Same thing that happens to the C6 side, the
 23 other side of the disc space.
 24 Q All right. Well, for example -- and you can
 25 correct me if I'm wrong, but 63081, there is one

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1 tight, so we want to start taking out bone. And
 2 in order to get that, we sometimes have to shave
 3 down from the top down. We do that. We take
 4 additional bone.
 5 We have to even out the surfaces, so
 6 you have to remove additional bone for that. So
 7 there is a lot of shaping of the -- of the C5
 8 and C6 vertebral bodies, one, to remove
 9 ligament, to remove any osteophytes, and to make
 10 it all even. Because if it's not even, then you
 11 can't put the fusion device inside it to get it
 12 to heal. So there is a lot of work to be done.
 13 There is continuous bleeding, so the
 14 assistant is there to help suction any bleeding.
 15 He's there to help me hold tissue back. Because
 16 when he has to retract the esophagus and trachea
 17 in order for me to work, he's looking through
 18 there, he's identifying any additional bleeders
 19 that I may not see. He's suctioning.
 20 So it's a symphony of two people
 21 working together. I can't do this case by
 22 myself. It's very difficult. And so without
 23 the -- without a highly skilled assistant --
 24 because I can bring in an assistant, and if they
 25 don't have knowledge, if they're not skilled, if

1 on top, and then there is one below --
 2 A Correct.
 3 Q -- for you, so -- and we said those were the
 4 corpectomies, one for the C5 and one for the C6;
 5 is that right?
 6 A Well, 63081 is for the C5.
 7 Q Okay.
 8 A And then 63082 is for the C6.
 9 Q All right. So what's the second 606301 [sic]
 10 down below for?
 11 A You're talking about why are there two 63081s
 12 and --
 13 Q Correct.
 14 A Well, there is one 63081 for Beau.
 15 Q Yes.
 16 A And one for me.
 17 Q Ah, but they include both C5s?
 18 A Well, remember, I said that we both work
 19 together.
 20 Q You both work together. Fine.
 21 A And convention -- so I, again, did not invent
 22 billing convention, you're asking me
 23 questions --
 24 Q Yeah.
 25 A -- that really I am not the expert on.

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1 Q Yeah.		1 A -- vertebral body. It doesn't say that 63081 is
2 A The way it works is he and I both do the		2 C5 --
3 corpectomy.		3 Q No.
4 Q Correct. I've got that. I understand that.		4 A -- or 63082 is C6. It doesn't say that. It
5 A And because we both work together, there is a		5 just says that that's one corpectomy, and then
6 bill for him, and there is a bill for me.		6 the other one is the additional. And it really
7 Q Okay. But 63082 is an entirely different code.		7 just depends on how you read the operative
8 Why would you use a different code for the same		8 report.
9 surgery, same -- one is a C5 and one is a C6,		9 Q So this is the question:
10 doesn't it make more sense that the 63081 down		10 Are we breaking down this surgical
11 below is for the C6, for example?		11 procedure by C5 and C6, or are we breaking it
12 A No. Because the coding -- again, not my policy,		12 down by provider, in this case by you and your
13 but the coding rules require that the other		13 assistant, Beau?
14 vertebral body get -- gets its own code and it's		14 A I think -- I think you have to do both. I mean,
15 a different code and it's called the additional		15 I think that's -- again, that's the convention.
16 corpectomy code.		16 We -- we are -- you know, we are not given a
17 Q Okay. But I thought 63082 was for		17 choice on how to bill this. This is the way
18 decompression. No?		18 billing is done.
19 A It -- yeah. It's for the corpectomy.		19 Q All right. So what is 2251 [sic], then, what --
20 Vertebrectomy and decompression of the cord.		20 what -- what part of this entire process is
21 Yes.		21 that?
22 Q Okay. So what I'm suggesting to you is that		22 A That is the arthrodesis, which is basically
23 there is a series of numbers at the top of the		23 getting the surface of the vertebral bodies
24 different codes that were done for C5, and then		24 prepared for the fusion so that you can put a
25 we start again under your name, for example, for		25 spacer in there. So that means evening it out,
Page 63		Page 65
1 C6 with --		1 taking -- making sure if there is any excess
2 A No.		2 bleeding, that's taken care of. I mean, all
3 Q You don't see it that way?		3 those little things we have to do.
4 A No.		4 Q Okay. And that's commonly referred to as a
5 Q Okay.		5 fusion, perhaps?
6 A And I think that maybe you're misinterpreting,		6 A It could be.
7 and I don't know.		7 Q Arthrodesis?
8 Q Well, that's what we're here to find out.		8 A It could be. Yeah. Arthrodesis is just the
9 A So there is a set of codes for Beau, and so		9 medical term.
10 there is a 63081, 82, 22 -- I mean, a bunch of		10 Q Okay. And he charged 7,500, and you charged
11 codes for Beau.		11 20,625; is that correct?
12 Q Yes.		12 A That is correct.
13 A And then there is a bunch of codes for me.		13 Q All right. And then 22853, do you know what
14 Q Correct.		14 that is?
15 A And since he and I are both working together, we		15 A That's the -- getting the vertebral spacer
16 are required to bill each code to each provider,		16 ready.
17 so you don't just -- so, I mean, if we're both		17 Q Is that also referred to as the cage?
18 working on the corpectomy, we have to bill each		18 A Yes.
19 of us -- each of us separately.		19 Q Describe that again, please.
20 Q Okay. So there is no breakdown, then, on this		20 A So we get a cage -- well, first we have to
21 sheet for C5 and C6?		21 measure the size of the cage. We do trials. We
22 A Well, I think there is a breakdown because to		22 get the cage. We fill it with bone from the
23 me, you know, it doesn't -- it depends on which		23 patient, put cadaver bone in there. We put it
24 one you assign to which --		24 into the -- we put it into the spacer, make sure
25 Q Yeah.		25 it's large enough, but not too large. We tap it

	Page 66	Page 68
1 in and then make sure it's countersunk 2 appropriately. 3 Q And his charge for that was 1,770, and your 4 charge was 4,866; is that correct? 5 A That is correct. 6 Q And then we have 22845, do you remember what 7 that is? 8 A Yeah. That's putting in the cervical plate. 9 Q And what is the plate, again, please? 10 A The plate is a titanium plate that we put on the 11 surface of the C5 and C6, put screws in and 12 anchor it to the bone. 13 Q And he charged \$3,826 for that, and you charged 14 \$10,519 for that; is that correct? 15 A That is correct. 16 Q And there is a number of other codes in here, 17 but there is only one of those. For example, 18 61783, do you know what that is for? 19 A Let me see here. Yeah. That's for -- so we 20 spent time with preoperative planning, so 21 that -- we can charge for that. And then we 22 used some navigation, so we just took some 23 X-rays and then we put it into a navigation 24 system just to make sure our screws and our 25 plate were as even as possible.	1 area? 2 A I don't do that, I haven't looked at it, so I 3 wouldn't be shocked or surprised. I -- you 4 know, I just don't do that. 5 Q Well, I'm going to hand you Exhibit No. 10, and 6 Exhibit No. 10 is for code 63082, which I call 7 the decompression. And it says the average cost 8 for that procedure in the United States is 9 around 1,300, and you charge 9,200 averagely, 10 but -- which is less than what you charged in 11 this case. 12 A Okay. 13 Q Is that surprising to you? 14 A I -- I don't know anything about this service, 15 and I don't know how accurate they are, so I -- 16 I mean, thank you for this piece of paper, but I 17 really don't put a lot of faith in it. 18 Q Okay. Well, it's pretty accurate to you; isn't 19 it? It lists pretty close to what you charged 20 for this, although it's under, they were 21 conservative here, you charged more than this in 22 this particular procedure? 23 A And I don't know how they get their numbers. 24 Q Yeah. All right. And Beau -- Beau Boedecker's 25 name is listed here and he's your assistant from	Page 69
1 Q Is that the so-called Stealth system? 2 A Yes. 3 Q And then 77003? 4 A That's for taking X-rays and interpreting the 5 X-rays and so forth. 6 Q That's the fluoroscope? 7 A Yes. 8 Q And that was a charge of \$987? 9 A Yes. 10 Q And, lastly, 69990? 11 A Yes. 12 Q That is for the -- 13 A Use of operating microscope. 14 Q All right. And there is one fee for that for 15 \$3,420; is that correct? 16 A That is correct. 17 Q All right. So I'm going to hand you what's been 18 marked as Exhibit No. 10. 19 Have you ever heard of consumer -- 20 internet consumer services where you can check 21 out what your doctor is going to charge you for 22 a service? 23 A No, I've never heard of that. 24 Q So you would be surprised to find out where your 25 price range is for services in the Milwaukee	1 this case and he's about a third of what your 2 rate is; is that correct? 3 A Again, I don't know how it gets their numbers, 4 and I'd have -- and I would have to do my own 5 analysis to tell you -- 6 Q Yeah. 7 A -- what our averages are. 8 Q Okay. 9 A So, I mean, again, thank you for this piece of 10 paper, but -- 11 Q Sure. 12 A -- again, I don't know how much weight I can put 13 on this. 14 Q All right. I'm going to hand you what's marked 15 as Exhibit No. 11, and 11 is for the 63081, the 16 vertebrectomy or the corpectomy. And that -- 17 once again, that lists your rate at 18,400, and 18 the average for this surgery is 5,491. 19 Is that surprising to you, that you're 20 over three times higher than the average? 21 A Again, I don't know what their numbers are. 22 And, again, you know -- again, I don't know if 23 that's the average for neurosurgeons with 20 24 years' experience. Is that the average, you 25 know -- you know, we're -- who's in this	Page 69

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1	average? You know, is it a -- is it a	1	the point now where what I do doesn't
2	neurosurgeon in XYZ city who just started out?	2	necessarily get trained at their seminars,
3	You know, I mean, we don't know what these	3	because you really can't learn from a two-day
4	numbers are.	4	seminar how to do something very complicated,
5	You know, so I -- I think that	5	you know. And I used to go to these things a
6	absolutely there is going to be variation.	6	lot, and there is -- it's really just a taste of
7	Absolutely. But, you know what -- you know,	7	something. It doesn't really teach you
8	there is going to be variation in car prices.	8	anything.
9	There is variation in hotel prices. There is	9	So, you know, there wasn't a ton of
10	variation in airline prices. So absolutely	10	value to go to that, so I pretty much keep my
11	there is going to be variation.	11	meetings to the American -- AANS, American
12	Q Lastly, I'm going to hand you what's been marked	12	Association of Neurological Surgeons. It's
13	as Exhibit No. 12. That is the -- for the	13	broader. It gives me both cranial and spine and
14	fusion, 22551 code. And there your price is	14	peripheral nerve --
15	listed at 18,750, with the average cost being	15	Q Okay.
16	about 5,500 in the United States.	16	A -- education.
17	Once again, I assume you would testify	17	Q Were you aware that the North American Spine
18	just as you did the previous two that --	18	Society publishes appropriate use criteria for
19	A Yeah. Basically I don't know how -- how much --	19	the surgery that you performed on Ms. Gard here?
20	how value this has -- how much value this has.	20	A I'm sure that they do.
21	Q But this -- the price that's in here for all	21	Q You've heard of -- so it's called a checklist,
22	three of these is actually less than what you	22	that one should go and look through that
23	charged in the incident matter?	23	checklist to see what -- for example, what the
24	A The price is this is --	24	patient is exhibiting which could be objectively
25	Q Yes.	25	seen as necessitating the need for the surgery?
	Page 71		Page 73
1	A -- less than what we charge --	1	A Sure. Sure.
2	Q In Exhibits 10, 11, and 12, the price they have	2	Q Okay. And did you do that in this incident
3	for you, the average price, is less than what	3	case?
4	you charged in the incident matter here today?	4	A No, I didn't go through the checklist --
5	A Yeah. But you don't know how they even come up	5	Q Okay.
6	with any of these numbers, you know. Is it from	6	A -- because a checklist doesn't always -- if you
7	the year 2010? Is it from the year 2019? We	7	don't know what you're doing, then go to a
8	don't know. So, I mean, it's great to print	8	checklist. You know, get a page out of a
9	this from the internet. I -- I'm impressed that	9	textbook, read it through, and then follow the
10	you're able to find it, but to me it has no	10	recipe, you know. You know, if you're a
11	value.	11	Michelin star -- star chef -- and I'm not saying
12	Q Well, thank you for the compliment, and I	12	I'm a Michelin star neurosurgeon -- you know,
13	appreciate your opinion.	13	they don't go to a recipe -- Julia Child's
14	So going to -- back to the surgery in	14	cookbook and say "How I do make XYZ?" You know,
15	this question. You're a member of the North	15	a lot of the stuff we do, you know, we use
16	American Spine Society?	16	standard of care and common sense.
17	A I used to be. I stopped going to the meetings.	17	Q But where does the standard of care come from?
18	I just didn't have time.	18	A Standard of care comes from talking to other
19	Q Okay. And tell us what that organization is.	19	neurosurgeons, from our meetings, textbooks, so
20	A I think it's just an organization of spine	20	forth, and cumulative experience.
21	surgeons throughout the country.	21	Q So in this particular case, as I understand your
22	Q Okay. And what -- do you find any value? Do	22	testimony, the only proffered reason for this
23	you attend their training seminars?	23	surgery was the subjective pain which Ms. Gard
24	A I haven't gone because our surgeries -- I mean,	24	was suffering?
25	we do cutting-edge surgeries, and I'm kind of at	25	A Correct.

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<p>1 Q So --</p> <p>2 A And there was some abnormalities on the imaging,</p> <p>3 too.</p> <p>4 Q Okay. And so just let me -- let me run down</p> <p>5 this checklist.</p> <p>6 So there was no neurological deficit?</p> <p>7 A No.</p> <p>8 Q No indication of instability?</p> <p>9 A No.</p> <p>10 Q No persistent loss of feeling, weakness, or</p> <p>11 muscle control?</p> <p>12 A No.</p> <p>13 Q No evidence of nerve compression?</p> <p>14 A No.</p> <p>15 Q No radicular pain?</p> <p>16 A No.</p> <p>17 Q No neck pain causing weakness or pain in the</p> <p>18 arms?</p> <p>19 A No.</p> <p>20 Q No numbness -- no numbness, tingling, or</p> <p>21 weakness?</p> <p>22 A No.</p> <p>23 Q All right. So you did not have occasion to meet</p> <p>24 with Ms. Gard to a significant period -- excuse</p> <p>25 me -- a significant period after the motor</p>	<p>1 that her pain improved when he treated those</p> <p>2 levels.</p> <p>3 Q Okay. So that tells us where the pain is coming</p> <p>4 from. What is there out there that tells us</p> <p>5 this pain was caused by the motor vehicle</p> <p>6 accident?</p> <p>7 A You know, I guess that's a great question. So I</p> <p>8 think you can't say based on that data that it</p> <p>9 was intrinsically for sure caused by the motor</p> <p>10 vehicle accident, because there is nothing on</p> <p>11 the imaging that has a little sign with an arrow</p> <p>12 pointing saying "Caused by the MVA." However,</p> <p>13 we never have that. We rarely do.</p> <p>14 So all we have is history, and history</p> <p>15 of pain, both what she had before and after the</p> <p>16 accident, and the imaging, and so we have to put</p> <p>17 all that together. And so basically the</p> <p>18 narrative is that, you know, she didn't have the</p> <p>19 neck pain before the accident, she has it</p> <p>20 afterwards.</p> <p>21 We -- certainly she goes through the</p> <p>22 entire gamut of non-surgical treatment, and</p> <p>23 really I think she wasn't looking for surgery,</p> <p>24 you know, and I wasn't looking to do surgery on</p> <p>25 her, as evidenced by our initial meetings. That</p>
Page 75	Page 77
<p>1 vehicle accident?</p> <p>2 A Can you be more specific with that question.</p> <p>3 Q Yeah. For example, she didn't see you within</p> <p>4 the week or a month after the accident; fair?</p> <p>5 A No. No, she did not.</p> <p>6 Q There was a significant period of time that</p> <p>7 elapsed in the chronological history before she</p> <p>8 had an opportunity to see you after the</p> <p>9 accident, she was referred to you by other</p> <p>10 doctors; is that correct?</p> <p>11 A That is correct.</p> <p>12 Q All right. So what can you tell us, what was</p> <p>13 the injury in your opinion that the motor</p> <p>14 vehicle accident caused here that necessitated</p> <p>15 your surgery?</p> <p>16 A I believe the injury caused damage to the disc</p> <p>17 and damage to the facet tissue behind the spinal</p> <p>18 cord at that -- at the levels that she had</p> <p>19 between 5 and 6.</p> <p>20 Q And what objectively can you point us to, what</p> <p>21 CAT scan, what X-ray, what MRI which provides</p> <p>22 support to that opinion?</p> <p>23 A Yeah. Our review of the MRI show that the C5-6</p> <p>24 disc was abnormal looking. Additionally,</p> <p>25 Dr. Ong's diagnostic studies point to the fact</p>	<p>1 wasn't the conclusion that we were jumping to.</p> <p>2 And so I think, you know, the</p> <p>3 narrative is she approached this in a very</p> <p>4 reasonable manner and I think all her providers</p> <p>5 approached it reasonably and it wasn't until she</p> <p>6 got to the very end where she's, like, "You know</p> <p>7 what, I'm not getting 100 -- you know, I'm not</p> <p>8 getting the relief I really need, you know,</p> <p>9 let's discuss the surgical option." And -- and</p> <p>10 we talked about it. You know, there is no</p> <p>11 guarantees here.</p> <p>12 Q So you often use the phrase "disease" throughout</p> <p>13 your reporting here to describe the area that</p> <p>14 was the situs of the surgery. Why do you call</p> <p>15 it a disease?</p> <p>16 A It's just a general term. It's just -- because</p> <p>17 physicians treat disease. You know, I mean,</p> <p>18 it's a -- it can be an acute injury or disease.</p> <p>19 There is no subtext to that word, meaning that</p> <p>20 it's -- you know, I'm not implying that it's not</p> <p>21 related to the motor vehicle accident.</p> <p>22 Q Is that a common -- common term for surgeons to</p> <p>23 use the word "disease," when they really mean an</p> <p>24 acute injury?</p> <p>25 A Well, I think her injury -- because her</p>

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<p>1 injury -- when was her car -- when was her MVA 2 accident? When was the surgery? The surgery 3 was in 2019. So her accident was, was it in 4 twenty --</p> <p>5 Q Her -- the surgery was December 24th, 2019. 6 MR. KNOBLOCH: If I may, the accident 7 was March 27th of 2017.</p> <p>8 THE WITNESS: Okay. So it's been two 9 years; right? Approximately two -- over two 10 years. So, I mean, first and foremost, you 11 know, we're -- I'm not treating an acute injury, 12 you know, because I didn't even meet her until 13 well after her motor vehicle accident, so I'm 14 not treating an acute injury.</p> <p>15 Number two, you know, we just -- I use 16 the word "disease" because that's just -- you 17 know, that's an easy term to use. And I think 18 that certainly if you want to interpret that to 19 mean something different, certainly you could do 20 that, but in my mind, you know, she's got pain, 21 she's got damage, and that's part of the 22 disease. You know, that's part of the problem. 23 So "disease" and "problem," you know, in my mind 24 are interchangeable.</p> <p>25</p>	<p>1 interchangeable than --</p> <p>2 A I think to the common layman, yeah, you know, 3 and certainly you can push that point. But in 4 my interpretation "injury," "damage," "disease," 5 I mean, that's -- you know, that's what I'm 6 thinking.</p> <p>7 Q Okay. Now, you talked earlier under direct 8 examination that -- if I understood your 9 testimony, that Ms. Gard was complaining that 10 she wasn't receiving any permanent relief, and 11 you talked about providing permanence with 12 surgery?</p> <p>13 A That was the goal.</p> <p>14 Q Okay. And, in effect, you only had a 20 percent 15 success with that; is that correct?</p> <p>16 A That is correct.</p> <p>17 Q So you did not achieve permanence?</p> <p>18 A I didn't achieve a -- greater than 50 percent, 19 which is what I believe to be roughly the 20 standard, pain relief. Did we achieve 21 permanence? I think permanence is more an issue 22 of time. And so if she got 20 percent relief 23 forever, then we did achieve permanence -- a 24 modest permanence of pain relief.</p> <p>25 So I think for me "permanence" means</p>
Page 79	Page 81
<p>1 BY MR. PAWLAK:</p> <p>2 Q And do you think that's generally accepted in 3 the medical profession, to use that term of art 4 in such a fashion?</p> <p>5 A I don't know. I mean, it might be. It may not 6 be. I don't think it's super critical. I mean, 7 perhaps it's critical for you, but I don't think 8 it's super critical, because I think I know what 9 I'm talking about.</p> <p>10 MR. KNOBLOCH: And I have to correct 11 the record. It's March 24th of 2017. I don't 12 think it changes his testimony.</p> <p>13 BY MR. PAWLAK:</p> <p>14 Q Okay. So you also talk about degenerative 15 changes throughout your reports in terms of 16 describing the area that was the situs of the 17 surgery, don't you?</p> <p>18 A I may have mentioned some degenerative changes. 19 Yeah. I have to see the exact wording and 20 language. But, you know, at her age she's 21 probably going to have some degenerative 22 changes, and I think that is perfectly accurate 23 to assume that.</p> <p>24 Q And degenerative changes would be caused by 25 disease, aren't those two terms more</p>	<p>1 time, but I think your question is really the 2 degree of permanence or the degree of pain 3 relief. No. We didn't achieve a high level of 4 pain relief. Did we -- did we achieve pain 5 relief forever? We don't know because that -- 6 you know, we have to wait for that to come 7 through the wash.</p> <p>8 Q And you haven't seen Ms. Gard for a significant 9 amount of time; right?</p> <p>10 A That is correct.</p> <p>11 Q So you don't know what her situation is today; 12 correct?</p> <p>13 A I do not.</p> <p>14 Q All right. Is there any objective evidence out 15 there that you can point to that, in fact, 16 Ms. Gard's physical abilities have improved 17 since you performed the surgery?</p> <p>18 A I don't have any information.</p> <p>19 Q So when you say the goal -- you were -- if I 20 understand your testimony, your goal was you 21 thought the surgery would be a success if you 22 could permanently reduce her pain by 50 percent; 23 is that accurate?</p> <p>24 A Yeah. I mean, initially -- so, I mean, the word 25 "permanent" means that it's long-lasting</p>

<p>1 relative to what she was achieving from the 2 injections, and the goal was to achieve -- or 3 the aim was to get at least 50 percent pain 4 relief.</p> <p>5 Q So why didn't you simply recommend that she 6 continue with the facet procedures which she had 7 achieved significant success with 50 percent 8 improvement?</p> <p>9 A Is your question why didn't I recommend that --</p> <p>10 Q Yeah.</p> <p>11 A -- instead of the surgery?</p> <p>12 Q Yeah.</p> <p>13 A We did. We, in fact, recommended that she 14 continue that as long as she can. She was not 15 getting relief long enough with the facet 16 procedures, and facet procedures are -- 17 especially radiofrequency, over time becomes 18 less and less effective.</p> <p>19 Q And is it the same with the ablation procedure?</p> <p>20 A Yes. Yeah. So they become -- over time they 21 become less effective.</p> <p>22 Q Is she -- can she undergo these procedures even 23 now, after the surgery?</p> <p>24 A Yes. Yes, she can.</p> <p>25 Q How is it that the ablation procedure, which as</p>	Page 82	<p>1 Q So you don't know what you were paid today. 2 Okay. And you don't know if you received any 3 payment whatsoever for the surgery that you 4 performed?</p> <p>5 A Yeah. I -- I am assuming from Exhibit 9, if 6 this is accurate -- and I don't know when this 7 was -- so this looks like this was generated in 8 March 2021. It says we haven't been paid.</p> <p>9 Q Yeah. Okay.</p> <p>10 A So if we haven't been paid by March 2021, I 11 doubt that we got paid, you know, at all.</p> <p>12 MR. PAWLAK: All right. That's all I 13 have. Thanks.</p> <p>14 EXAMINATION</p> <p>15 BY MR. KNOBLOCH:</p> <p>16 Q A couple follow-up, Doctor. You have Exhibit 9 17 there in front of you. We've had an extensive 18 discussion today about the codes and whatnot. 19 That discussion also included billing for your 20 time and also billing for your assistant or your 21 physician assistant's time. I want to talk 22 about that concept in general. 23 Is it common in your experience, 24 Doctor, for neurosurgeons or any surgeon to bill 25 for their own time and also bill for an</p>
<p>1 I understand you said you -- it removes or it 2 desensitizes the nerve endings, do those nerve 3 endings grow back eventually?</p> <p>4 A Yes.</p> <p>5 Q You talked earlier -- briefly talked about the 6 physical therapy. 7 You -- you're not really familiar with 8 the physical therapy procedure that she went 9 through at all, are you?</p> <p>10 A I'm not a therapist. No.</p> <p>11 Q Okay. You don't know if she missed 12 appointments?</p> <p>13 A I do not.</p> <p>14 Q And you don't know if she was urged to schedule 15 additional appointments or how hard she worked 16 at any of that; right?</p> <p>17 A No. I was not there with her.</p> <p>18 Q So how much have you been paid today for your -- 19 today and any other cooperation you made with 20 the plaintiff for your testimony in this regard?</p> <p>21 A For today, I don't know. I would have to talk 22 to my manager. She -- she processes all that.</p> <p>23 Q Okay. Is that your booking agent or your 24 manager?</p> <p>25 A Kind of does both.</p>	Page 83	<p>1 assistant's time?</p> <p>2 A Yeah. So it depends on the practice. So there 3 is a lot of practices where two neurosurgeons 4 will work together, and the primary surgeon gets 5 paid the lion's share of the fee, and then the 6 assistant surgeon will get paid a fraction, 7 whatever that may be. 8 Because practices have grown, because 9 neurosurgeons are in short supply, often 10 physician extenders, PAs, are now involved. And 11 they -- and they -- what they do is no less 12 skilled than what a second neurosurgeon would 13 do, you know, and so a really good physician 14 assistant can do pretty much what another 15 neurosurgeon does. There is a lot of rules and 16 regulations that they have to do it under 17 supervision, but they're very skilled. So 18 that's -- that's how it works.</p> <p>19 Q Is it fair to say with respect to the codes and 20 the procedures and what you can bill and how 21 much you can bill and what codes for this -- 22 this, that, and the other thing, are those 23 ever-changing within your industry, would you 24 say?</p> <p>25 A I mean, the codes can change because it's all</p>

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1 determined I guess by a larger body that 2 determines these codes. So the code numbers can 3 change, but the idea, the principles, don't 4 change.	1 MR. KNOBLOCH: Is your only objection 2 to the therapy records? 3 MR. PAWLAK: What was the other one 4 that he -- well, all of the other records, too, 5 that he testified that were reasonable, it's my 6 position that -- I'm not -- I'm not opposed to 7 the document coming in for what it says on the 8 face of it. I'm -- what I'm objecting to is his 9 opinion that they're reasonable.
5 Q Regardless of your charges and the codes 6 associated with them, do you have any reason to 7 dispute that Ms. Gard was actually charged -- 8 looking at Exhibit 9 -- this \$101,527 by your 9 office for the totality of the treatment 10 received by you?	10 Now, we can let those documents in for 11 face value, but I'm not agreeing that his 12 testimony that they're reasonable is relevant. 13 And I guess we can deal with that, if you're 14 relying on that for some purpose.
11 A I mean, yes, I believe that this -- these were 12 the charges that were sent out.	15 MR. KNOBLOCH: Well, I'm trying to 16 figure out the distinction.
13 Q What I was getting at is -- well, strike that 14 question. 15 MR. KNOBLOCH: I would like to move 16 those exhibits that I proffered earlier into 17 evidence, but subject to that, I have nothing 18 further.	17 MR. PAWLAK: Yeah. Yeah. 18 MR. KNOBLOCH: It's going to come in 19 on its face, so the numbers are going to be 20 heard by the Court.
19 Any objection to that? 20 MR. PAWLAK: Well, I don't know if we 21 want to keep -- I would like to have a 22 discussion with you afterwards, or unless you 23 want to do it now on the record now about those 24 exhibits.	21 MR. PAWLAK: The number is going to be 22 heard. 23 MR. KNOBLOCH: The Court still has to 24 make a determination on reasonableness.
25 MR. KNOBLOCH: Well, how long it is it 1 going to take? Let's -- I would prefer to do it 2 on the record, so we don't have to brief it 3 after. 4 MR. PAWLAK: Okay. Well, yeah. My 5 issue is if your intention is to enter, like, 6 for example, the physical therapy records based 7 upon the testimony of this witness, yeah, I'm 8 opposed to that.	25 MR. PAWLAK: Yeah. Page 87 1 MR. KNOBLOCH: I think there was 2 enough foundation, shaky or not, that his 3 testimony comes in, and I think your cross goes 4 to the weight of the evidence, not to the 5 admissibility of it, so I think it comes in, and 6 the judge is going to have to weigh it all -- 7 MR. PAWLAK: Okay. 8 MR. KNOBLOCH: -- and come to a 9 reasonable number. 10 MR. PAWLAK: I will -- then what I 11 will do is I will -- 12 MR. KNOBLOCH: We're almost done, 13 Doctor. 14 MR. PAWLAK: Yeah. I'm going to -- 15 I'm going to keep my objection there, then, 16 based upon that provision that it goes to the 17 weight of it. So if I think if I -- I'm going 18 to have to preserve that objection. If she says 19 it comes in and then she decides the weight 20 based upon the direct and the cross, then we can 21 deal with that. So I'm going to -- I'm going to 22 keep my objection. 23 MR. KNOBLOCH: As to what 24 specifically? 25 MR. PAWLAK: Well, I'm going to keep
10 to us coming to a stipulation that those records 11 can entered on the face of it for what they're 12 worth, in the sense that she went to therapy on 13 those days. I just object -- he doesn't have 14 the foundation, I don't think, to say that 15 that's reasonable based upon his -- his, you 16 know, carefree review here today, and I don't 17 think he possesses the expertise, as he's 18 indicated there. 19 So, I mean, but I'm -- that being 20 said, I think we can come to arrangement to get 21 those in. Otherwise you can move and I can 22 object and we can let the judge decide, but I 23 think we can probably work that, depending on 24 what you want to do with those physical -- if 25 you just want to --	Page 89 1 MR. KNOBLOCH: I think there was 2 enough foundation, shaky or not, that his 3 testimony comes in, and I think your cross goes 4 to the weight of the evidence, not to the 5 admissibility of it, so I think it comes in, and 6 the judge is going to have to weigh it all -- 7 MR. PAWLAK: Okay. 8 MR. KNOBLOCH: -- and come to a 9 reasonable number. 10 MR. PAWLAK: I will -- then what I 11 will do is I will -- 12 MR. KNOBLOCH: We're almost done, 13 Doctor. 14 MR. PAWLAK: Yeah. I'm going to -- 15 I'm going to keep my objection there, then, 16 based upon that provision that it goes to the 17 weight of it. So if I think if I -- I'm going 18 to have to preserve that objection. If she says 19 it comes in and then she decides the weight 20 based upon the direct and the cross, then we can 21 deal with that. So I'm going to -- I'm going to 22 keep my objection. 23 MR. KNOBLOCH: As to what 24 specifically? 25 MR. PAWLAK: Well, I'm going to keep

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1 it to the physical therapy -- I'm going to keep 2 it to the physical therapy records. If you're 3 relying upon him to get those into the record, 4 that's -- that's my -- that's the crux of my 5 objection.	1 for what they're -- for the same reason. The 2 Judge can decide whether or not -- 3 MR. KNOBLOCH: No objection. 4 MR. PAWLAK: -- what weight she wants 5 to give them. Okay. Thank you.
6 MR. KNOBLOCH: Okay.	6 MR. KNOBLOCH: All right. We're done.
7 MR. PAWLAK: I don't buy his testimony 8 that they're reasonable. If they have to be 9 reasonable to come into the record, then I'm 10 objecting to it, I guess, because I don't think 11 they're reasonable. That's part of my argument 12 in this case.	7 THE VIDEOGRAPHER: We're going off the 8 record. The time is 5:15 p.m. This concludes 9 today's testimony. The total number of media 10 units used today is one.
13 MR. KNOBLOCH: But we're focused just 14 on the therapy at this point?	11 (Proceedings concluded at 5:15 p.m.)
15 MR. PAWLAK: Therapy record and -- 16 well, of course, all of his charges, too. I 17 mean, they're there. I agree that they 18 happened, obviously. We know that they were 19 billed out. I'm objecting on the issue of their 20 reasonableness.	12 13 14 15 16 17 18 19 20 21 22 23 24 25
21 MR. KNOBLOCH: Sure. You can preserve 22 all objections --	
23 MR. PAWLAK: Okay.	
24 MR. KNOBLOCH: -- to reasonableness --	
25 MR. PAWLAK: Yeah.	
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1 MR. KNOBLOCH: -- because that's, in 2 my mind, a jury question or a Court question -- 3 MR. PAWLAK: Yeah. 4 MR. KNOBLOCH: -- so I don't know if 5 you're -- you need to place it. 6 But as far as the admissibility of 7 these documents, that's what I would like to get 8 straightened out here on the record. So I would 9 like to move those --	1 STATE OF WISCONSIN) 2 COUNTY OF MILWAUKEE) 3 4 I, Sarah M. Gilkay, RPR, RMR, CRR, and 5 Notary Public in and for the State of Wisconsin, 6 do hereby certify that the preceding deposition 7 was recorded by me and reduced to writing under 8 my personal direction. 9 I further certify that I am not a 10 relative or employee or attorney or counsel of 11 any of the parties, or a relative or employee of 12 such attorney or counsel, or financially 13 interested directly or indirectly in this 14 action. 15 In witness whereof, I have hereunder 16 set my hand and affixed my seal of office on 17 this 28th day of February, 2022. 18 19 20 21 22 23 24 25
10 MR. PAWLAK: Yeah. 11 MR. KNOBLOCH: -- into evidence. 12 MR. PAWLAK: Okay. That's fine. 13 MR. KNOBLOCH: So no objection? 14 MR. PAWLAK: I think I've gone over 15 backwards trying to preserve my --	<%26888,Signature%> _____ Sarah Gilkay RPR, RMR, CRR, and Notary Public My commission expires March 8th, 2026
16 MR. KNOBLOCH: So just to be clear, no 17 objection to my exhibits --	
18 MR. PAWLAK: Coming into the record. 19 Right. Yeah.	
20 MR. KNOBLOCH: Okay. 21 MR. PAWLAK: That's fine. 22 MR. KNOBLOCH: All right. I think 23 we're done.	
24 MR. PAWLAK: And then I'll -- excuse 25 me. I'll move my exhibits in the record, too,	

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